

**The Center for Attachment and Family Development**  
**Emma Jane Baker**  
**Treatment Protocol**

**Mission Statement:**

Giving Hope, creating strength, empowering lives through treatment, education, and support.

**Philosophy:**

The philosophy of the Center is to enable the growth of families and children with Developmental Trauma through a multifaceted outpatient approach. We help parents to create the best possible environment for their child to grow and attach through encouraging healthy family interactions, maintaining safety, and implementing treatment modalities that help a child normalize emotionally and physically destructive behaviors.

**Description of processes:**

**Intake/Admission:**

The admission process begins with an in-depth application. The application gathers demographics and insurance information for mother, father, child, and others living in the home. Medical, psychosocial, and placement history are included in the application.

The initial intake includes in depth questioning regarding the family of origin history for the child, including dates of last contact, termination of parental rights, occupations, criminal history, and whether or not the child knows this information. History is requested regarding the child's prenatal, birth, developmental, placements, educational history, mental health treatment history, and psychotropic medication history.

**Assessment:**

Parents fill out an RADQ, CBCL, and a narrative describing a typical day with the child. Parents also write narratives (autobiographies) for themselves with particular attention to their own families of origin, why/how they came to have this child, and how their lives have changed since the child came to live with them. They are asked to include their expectations for therapy. Children fill out a Sentence Completion and Drawing assessment.

These assessments and histories are reviewed with parents prior to planning a treatment course of action.

### **Treatment planning:**

The planning involves reviewing all of the intake and assessment information and a minimum of interviews with parents only to develop an overall plan for intervention. Parents are essential members of the treatment team that includes therapists, the child, and input from medical personnel and psychiatrists. Informed consent of the client and family regarding release of medical records, safety issues, and treatment techniques is also a part of treatment planning.

Generic plans for families/children include building trust, empathy, attunement, communication skills, and reciprocal behaviors. Another goal for the family is to increase the quality of physical and emotional closeness through the use of positive touch, nurturing, and humor and playfulness.

### **Treatment Techniques:**

#### *For the child and family:*

- a. Use of supportive language and cognitive therapy, cooperative play, and cooperative nurturing to create a safe, nurturing, and empathetic climate for therapy.
- b. Planning and facilitating ongoing monitoring and education to maximize attunement, parenting skills, and trust.

#### *For the child:*

A full range of therapeutic techniques are employed to ultimately help the child willingly and appropriately surrender control to parents in a healthy way while increasing the child's readiness to rely on the parent for safety, help, comforting, and nurturing. These techniques include:

- a. Kinetic activity that is diagnostic and enjoyable for the child includes drawings, clay art, play activities, and nurturing time with parents in a controlled directive setting.

NEUROFEEDBACK when requested by educated parents to facilitate brain based intervention that leads to a more psychologically available child.

- b. Therapeutic contracting for behavior management, and goals, written and verbal.

- c.** Homework: journaling when appropriate, assignment of responsibilities with a representative inner-child, i.e., teddy bear, stuffed animal.
- d.** Parents participating in nurturing time: peaceful holding, cuddling, early childhood games, bottle time, and puppet games to facilitate emotional development.
- e.** Therapist nurturing holding when appropriate during discussions of difficult subjects to allow the child to be emotionally available and feel safe for emotionally difficult work.
- f.** Psychodrama, confrontation of behaviors and faulty thinking, and integration of body, feelings, and mind are used as needed.
- g.** When available birth parent letters, court records, and other documents are used to help the child understand birth and early childhood history.
- h.** Consulting with a child to help them make better choices and create a link for cause and effect thinking that leads to reciprocity.

***For Parents:***

- a.** Education regarding parenting the attachment cycle and the effects of developmental trauma or traumatic breaks in the attachment cycle as it relates to emotional and cognitive functioning. Education also includes learning to achieve a healthy balance of boundaries, nurturing, encouragement, and disengagement from unnecessary control battles.
- b.** Supportive cognitive therapy to unlock their own frustrations and hurts as well as to express their own emotional responses to past/present situations. Therapy also supports the parents need to maintain control over the family environment while assisting the child to feel safe enough to relinquish his/her compulsive need to be in control.
- c.** Parents participate in sessions, in the room with the child and/or watching from another room.
- d.** Homework for parents; journaling and weekly updates to therapist via phone or email prior to therapy session.
- e.** Referrals for parental marital therapy and/or treatment for medical/emotional issues are made as needed.

***For Siblings:***

- a.** Individual therapy as needed to help a sibling express emotional responses, frustrations, and hurts to past/present situations.
- b.** Inclusion of siblings in family therapy sessions to ensure that all members of the family are responding in a healthy way to the therapeutic process.

**Safety/risk management plan:**

Safety and risk management are high priorities and are clearly defined and constantly monitored.

- a.** All participants ensure that the physical and emotional health and welfare of everyone involved in an intervention is monitored at all times.
- b.** A child is never restrained or has pressure put on them in such a manner that interferes with basic life functions.
- c.** Parents and/or other individuals who participate observe and monitor the therapy process.
- d.** While some forms of touch are appropriate and useful, sexual touch is never used.
- e.** No form of shaming, demeaning, or degrading interaction is used as therapeutic interventions.
- f.** Therapists do not use, model, or endorse as punishment the use of treatment options, i.e., holding, sitting, paradoxical interventions, confrontations, ect.

**Evaluations/outcomes/follow-up:**

Assessment outcomes are tracked via the RADQ, CBCL, and Neurofeedback Data at the beginning, mid point, and end of therapy. Every three months the treatment plan is re-evaluated to evaluate or change the treatment plan as needed.

Follow-up for parents/children include contact at six months and then at a year after treatment for verbal assessments, and/or CBCL, RADQ to assess positive treatment outcomes and/or opportunity for further therapy as needed.